1. PURPOSE / CONTEXT

1.1. To establish clear system for hospital wide reporting of information related to medical / health care error, and to provide a confidential mechanism of identification, tracking, trending and follow up of all incidences that pose an actual or potential safety risk to patients, families, visitors and staff.

2. SCOPE / APPLICABILITY

2.1. Hospital Wide

3. DEFINITIONS

3.1. Error

3.1.1. It is an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.

3.2. Variance

3.2.1. It is defined as any event or circumstances not consistent with the standard routine operation of the hospital and its staff or the routine care of a patient / visitor.

3.3. Near Miss

3.3.1. Any process variation which did not affect the outcomes but for which a recurrences carries a significant chance of a serious adverse outcome is called near miss. Such a near miss falls within the scope of definition of a

sentinel event that is subject to review by the joint commission under its Sentinel Event Policy.

3.4. **Serious Event**

3.4.1. An occurrence that results in an adverse outcome to a client treated by the program but does not meet the definition of a “sentinel” event.

3.5. Sentinel Events:

3.5.1. An unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function* for a recipient of health care services.

3.5.2. Major and enduring loss of function refers to sensory, motor, physiological, or psychological impairment not present at the time services were sought or begun. The impairment lasts for a minimum period of two weeks and is not related to an underlying condition.

3.6. Surgical events

Surgery performed on the wrong body part

Surgery performed on the wrong patient

Wrong surgical procedure performed on the wrong patient

Retained instruments in patient discovered after surgery/procedure

Patient death during or immediately post surgical procedure

Anesthesia related event

Device or product events

Patient death or serious disability associated with:

The use of contaminated drugs, devices, products supplied by the organization

The use of function of a device in a manner other than the device's intended use

The failure or breakdown of a device or medical equipment

Intravascular air embolism

3.7. Patient protection events

3.7.1. Patient death or serious disability associated with elopement from the health care facility

3.7.2. Patient suicide, attempted suicide, or deliberate self-harm resulting in serious disability

3.7.3. Intentional injury to a patient by a staff member, another patient, visitor, or other

3.7.4. Any incident in which a line designated for oxygen or other came to be delivered to a patient and contains the wrong gas or is contaminated by toxic substances

3.8. Environmental events

3.8.1. Patient death or serious disability while being cared for in a health care facility associated with:

3.8.2. A burn incurred from any source

3.8.3. A slip, trip, or fall

3.8.4. An electric shock

3.8.5. The use of restraints or bedrails

3.9. Care management events

3.9.1. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO- incompatible blood or blood products

3.9.2. Medication error leading to the death or serious disability of patient due to incorrect administration of drugs, for example:

Omission error

Dosage error

Dose preparation error

Wrong time error

Wrong rate of administration error

Wrong administrative technique error

Wrong patient error

3.9.3. Patient death or serious disability associated with an avoidable delay in treatment or response to abnormal test results.

3.10. Criminal events

3.10.1. Any instances of care ordered by or provided by an individual impersonating a clinical member of staff

3.10.2. Abduction of a patient

3.10.3. Sexual assault on a patient within or on the grounds of the health care facility.

3.10.4. Death or significant injury of a patient or staff member resulting from a physical assault or other crime that occurs within or on the grounds of the health care facility.

4. RESPONSIBILITIES

4.1.1. Sentinel Event Review Team (SERT) –

4.1.2. Director Medical Service

4.1.3. administrator

4.1.4. Senior Consultant

4.1.5. Dy.M.S

4.1.6. COO – Operations

4.1.7. Nursing Director

4.1.8. Nursing Superintendent

4.1.9. Quality Officer (QO)

4.2. Additions to SERT to be determined by the event, but will include, at a minimum all staff who were involved in the occurrence.

4.3. SERT to identify and write consultant who needs to be involved in this process.

4.4. Any staff member with first knowledge of a potential sentinel event or of a near miss event is responsible.

4.4.1. To intimate to immediate supervisor (or)

4.4.2. To intimate to concerned HOD / In charge (or)

4.4.3. To intimate to appropriate personnel.

4.4.4. The concern supervisor / In-charge / HOD is responsible to intimate to any member of Sentinel Event Review Team (SERT) immediately.

4.5. SERT is responsible to document occurrence in the incident report and respond appropriately.

4.6. The incident report, documentation of the results of the event investigation, the resulting Root Cause Analysis (Sentinel Event – RCA form), the action plan and its implementation outcomes, and results of Quality Measures, all communication related to this process are to be maintained and protected by QO considering as strictly confidential information.

4.7. QO is responsible to coordinate all activities related to Sentinel Event policy.

5. POLICY

5.1. It is a policy of Apollo Hospital, Secunderabad, to identify, report, performing root cause analysis and implementation of corrective / preventive actions for all Sentinel Events occurred.

5.2. All sentinel events to be analyzed within 24 working hours of occurrence

6. PROCEDURE

6.1. GENERAL INFORMATION AND DESIRED OUTCOME

6.1.1. Medically Indicated follow up care or services should be provided to ensure the best possible outcomes for the injured parties, property and / or staff member.

6.1.2. Any occurrence that meets the definition of Sentinel Event should be reported through Incident reporting form

6.1.3. Incident report raised should be forwarded to the office of unit head within 24hrs from the incident occurrence

6.1.4. After documenting Administrator comments the same is to be forwarded back to concern supervisor / In charge / HOD for documenting root cause and corrective action taken within 24 hrs.

6.1.5. Root cause and corrective action taken along with severity rating is done and sent back to Unit head within 24hrs

6.2. Administrator to document the follow up comments and send the original copy of the same to Quality Assurance department within 24hrs.

6.3. IDENTIFICATION AND NOTIFICATION

6.3.1. Any staff member with first knowledge of a potential sentinel event should raise incident report

6.3.2. PRELIMINARY INVESTIGATION

6.3.2.1. SERT should conduct a preliminary investigation under the direction of unit head to determine if the incident is a sentinel event as defined by this policy.

6.3.3. This process includes (but not limited to) the following,

6.3.4. Fact finding activities, including peer review and interviews with persons involved / related to a sentinel event.

6.3.5. Written statements to gather an accurate description of the sequences of the events.

6.3.6. Review of the Medical Record

6.3.7. Sequestering and preserving appropriate evidence. (Confidentially)

6.3.8. If SERT determines that the event meets Sentinel Event criteria, Root Cause Analysis to be conducted and recorded in Sentinel Event – Root Cause Analysis form.

6.4. If the incident is determined not to fit the Sentinel Event definition, but it is a Serious Events or Near Miss as defined by this policy, an RCA should be conducted.

7. ROOT CAUSE ANALYSIS (RCA) AND ACTION PLAN

7.1. A thorough RCA to be conducted focusing primarily on process system human factor, equipment factor, controllable environmental factors, uncontrollable environmental factors, information management issues any other factors etc, but not on individual or individual performance.

7.2. RCA to be carried out with the consultation of appropriate experts / technical experts, as necessary.

7.3. The RCA identifies the changes that could be made to systems and processes, either through redesign or development of new systems and processes that would reduce the risk of such events occurring in the future.

7.4. RCA to be conducted as formal process, using accepted tools and techniques, including, but not limited to, Flow Charting, Cause and Effect Diagramming, Pareto Charts, etc.

7.5. The outcome of the RCA is an action plan which is identification of fact (s) responsible for event; the action plan identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

NOTE:

7.6. For each of the findings identified in the analysis as needing an action, indicate the planned action expected, implementation date and associated measure of effectiveness. (OR)

7.6.1. If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.

7.7. Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.

7.7.1. Consider whether pilot testing of a planned improvement should be conducted.

7.8. Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.

7.9. The SERT should continue to meet until the RCA process has identified the key Root Cause(s) that contributed to the event.

8. IMPLEMENTATION OF CHANGES

8.1. The SERT to develop an action plan with

8.1.1. Timeliness

8.1.2. Responsibilities

8.1.3. Risk reduction strategies

8.1.4. Measures of effectiveness

8.1.5. The concerned HOD and In charges are responsible,

8.1.6. To implement the action plan

8.1.7. To implement the system and process changes identified through Root Cause Analysis.

8.1.8. Implementation should generally be completed within six months or time specified in action plan, after the conclusion of the RCA. A report on status of implementation of action plan should be maintained to SERT by the concerned HOD / In charge. SERT should review the effectiveness and decide on further course of action as necessary